

Patients and Homoeopathy: an Overview of Sociological Literature

Gunnar Stollberg



THIS PAPER IS DIVIDED into three parts. First, an overview of the sociology of the doctor–patient relationship in general; secondly the sociology of homoeopathy as a heterodox form of medicine and as an element of medical pluralism; and thirdly some sociological views on patients in homoeopathy. The general thesis is that the homoeopathic doctor–patient relationship may be characterised both as being premodern, and being postmodern; as being an order characterised by partial expertise of the patient, and by longer patients' accounts.

Sociology of the Doctor–Patient Relationship

THE QUANTITATIVE ASPECT OF HOMOEOPATHY in Germany demonstrates that it is regularly practised by some 16,000 physicians. The professional organisation, the *Zentralverein homöopathischer Ärzte*, comprises some 3,000 members. Homoeopathy is the medical heterodoxy most frequently used in Germany. It is not the intention to give a quantitative sociology of homoeopathic patients, or to outline their numbers, their social structure and their sex in relation to biomedical patients etc., but rather to reflect upon the ways sociologists and historians perceive the doctor–patient relationship in its historical and its current forms.

The doctor–patient relationship is a classical topic of medical

sociology but the centrality of this relationship is no more than some hundred years old. Previously, a medical pluralism consisting of different healers can be found. As a 70-year-old German journalist put it in 1878: '51 (doctors) treated me ... up to now ... I do not count the sympathetics, magnetisers, magic healers, well-informed shepherds, and the old wives.'¹ This medical pluralism still exists and homoeopathy forms part of it. But the elements of this pluralism have changed and the doctor–patient relationship has become central. These processes form part of the medicalisation of society, which was a central topic of historiography in the 1980s.² Learned doctors were successful in establishing their 'jurisdiction'³ in the field of health and illness; based on scientific knowledge and supported by the state, they could make their way from a learned state to a modern profession and, thus, extend their power in society. The centrality of the doctor–patient relationship formed part of medicalisation. Starting from the educated middle classes, learned doctors were accepted as experts in all questions of health and illness reaching its peak in the decades after the Second World War. The structure of consultation in this period may be classed as, first, limited to an impatient and abbreviated style of history-taking and, secondly, cursory attention to physical examination while giving painstaking attention to laboratory data and diagnostic imaging.⁴ Shorter called this period 'post-modern' by contrasting it with the 'modern' nineteenth century. This period will be called 'modern', by contrasting it with the last three decades of the twentieth century, which have been conceptualised as a period of postmodernism and postindustrialism in Western countries.⁵ The 'modern' role of the patient will be juxtaposed with the 'post-modern' one.

First, the modern patient differed from that of the early nineteenth century in not being the dominant part in the doctor–patient relationship. Patients, in about 1800, formed the dominant part in the medical patronage system.⁶ Doctors were integrated into a form of public structure by the everyday life of their patients; there was a triangle shaped by the patient, her/his public and the doctor. Medical knowledge was shared by all members of the educated classes, whether medically trained or not. Learned doctors and other healers were consulted in a parallel manner; this parallelism was not an act of patients' counterculture.⁷ Secondly, the homoeopathic consultation did not undergo many changes on its way to modernity. Shorter characterised the structure of 'traditional' consultation at the beginning of the nineteenth century where the traditional doctor (1) did fairly well in history-taking; (2) virtually omitted any kind of clinical investigation, in the sense of observing and examining the patient; and (3) had almost no sense of differential diagnosis.⁸

In biomedicine, all these things changed during the course of the nineteenth century. The role of the patient in the 'modern' period was outlined by Parsons⁹ in a classical manner. He placed the doctor–patient relationship in the centre of medical sociology. This relationship was formed by two complementary roles. The achievement role was to be played by the doctor, and was characterised by scientific knowledge, by emotional neutrality etc. The complementary role to be played by the patient was characterised by the obligation to want to regain his/her health, in order to be able to fulfil functional roles in all other social systems. Therefore, the patient was obliged to be compliant, and to trust his/her doctor.¹⁰ Parsons' conception of the doctor–patient relationship was adopted by subsequent historiography. The progress of medical knowledge, practices and techniques was said to have enabled the doctors to detach themselves from the patients' control.¹¹ Parsons' medical sociology was criticised by Freidson, who differentiated between various patterns of doctor–patient interaction: in paediatrics and in surgery, the active doctor controls the passive patient (paediatricians and beauty surgeons certainly will see this point differently); interior medicine and the practice of general practitioners run a model of leadership and co-operation; in psychotherapy, in rehabilitation and in the treatment of chronic diseases mutual participation is necessary.¹² Neither Parsons nor Freidson extended their analyses to homoeopathy.

A number of sociological and linguistic studies performed in the 1970s and 1980s were dedicated to verbal communication between doctors and patients. The medical round in hospitals was analysed as a structural conflict between doctors and patients. The patients preferred to talk to their doctor, while the doctor preferred a bodily examination.¹³ Doctors played their roles as primary speakers; they conducted longer explanations, asked questions, interrupted their patients etc.¹⁴ Similar results were found in communications taking place in intensive care units.¹⁵ A negotiated order instead of a hierarchical order was recommended to improve doctor–patient communication.¹⁶ Mishler¹⁷ differentiated between a voice of medicine which was decontextualised and performed by the physician, and a voice of the life-world, performed by the patient and based upon biographical experience. He was criticised by Atkinson,¹⁸ who identified various voices performed also by doctors, one of personal experience, one of journal science, etc. Thus the dichotomic view of doctors and patients became replaced by a differentiated one.

In contrast to the thesis of the doctors' dominance, patients do influence medicine. Medical definitions of certain diseases, mostly psychiatric ones, have been advanced by medical lay persons. One example

is the post-traumatic stress disorder. Veterans of the Vietnam war co-operated successfully with sympathetic health professionals in defining this syndrome as a disease.¹⁹ Another example is the sudden infant death syndrome. Parents of children who had died from this phenomenon, co-operated with medical moral entrepreneurs.²⁰ Homosexuality was removed from the American medical index under the influence of the gay movement.²¹ A second form of patients' influence on medical expertise is the lay referral system.²² Most medical consultations confirmed the patients' view.²³ Thus, Tuckett *et al.* characterised biomedical doctor–patient consultations as 'meetings between experts'. Willems analysed the communications between a specialist in lung diseases, a general practitioner and their patient with the following result: 'What happens ... is a modification of the division of knowledge and skills between physicians and patients. A clear division between their seemingly fundamentally different competences becomes more and more fractal.'²⁴ The linguist Gülich analysed communications between medical experts and patients with similar results: 'The analysis of empirically ascertained data from authentic situations of communication renders terms like "expert" and "lay person" relative in a double sense: first it becomes clear that also lay persons can impart special knowledge to experts ...; secondly it is evident that the way in which the roles of experts and non-experts are constituted in interaction, is important for communication.'²⁵

Giddens saw that globalisation and de-traditionalising influences allowed many aspects of (post-)modern everyday life to be invaded by expert systems of knowledge. But this invasion intertwines with 'reflexivity', and medicine is characterised especially by a lay scepticism, which does not subvert trust, but makes it active:

All forms of expertise presume active trust, since every claim to authority is made alongside those of other authorities, and experts themselves often disagree with one another ... The prestige of science itself, so central to earlier phases of the development of modern institutions, becomes subverted by that very scepticism which is the motor of the scientific enterprise ... A person with health problems ... might still turn first of all to the sphere of orthodox science and medical technology to resolve them ... Against a backdrop of active trust mechanisms, however, the choice might very well be to get a second or third opinion. Outside orthodox medicine a host of alternative treatments and therapies vie for attention ...²⁶

Thus, more recent studies no longer see a dichotomy between doctors and patients, as outlined by Parsons. The patients' knowledge can best be characterised by Alfred Schütz's (1899–1959) ideal type of the well-

informed citizen. Schütz made a distinction between three types of social distribution of knowledge: that of the expert; that of the man in the street, and an intermediate type, that of the well-informed citizen.

The expert's knowledge is restricted to a limited field but therein it is clear and distinct ... The man on the street has a working knowledge of many fields which are not necessarily coherent with one another. His is a knowledge of recipes indicating how to bring forth in typical situations typical results by typical means ... [the well-informed] citizen stands between the ideal type of the expert and that of the man on the street ... To be well informed means to him to arrive at reasonably founded opinions in fields which as he knows are at least immediately of concern to him although not bearing upon his purpose at hand ... [He] considers himself perfectly qualified to decide who is a competent expert and even to make up his mind after having listened to opposing expert opinions.²⁷

Homoeopathy in Medical Pluralism

HOMOEOPATHY FORMS PART OF MEDICAL PLURALISM. This is true not only for the nineteenth century, but also today. What is medical pluralism? For the last hundred years, Western medical knowledge has spread worldwide. It is called academic medicine, because it is taught in universities, or biomedicine, because it uses biology and the natural sciences in general for reference. In addition, it has gained a dominant, but not exclusive, position in most countries of the third world. The medical pluralism consisting of Western biomedicine, American osteopathy and traditional Chinese medicine (TCM) on the island of Taiwan has been described by Kleinman.²⁸ Such a pluralism exists also in Germany. Biomedicine, folk medicine, homoeopathy and naturopathy formed its elements at the end of nineteenth century. Anthroposophical medicine was added after the First World War, while folk medicine declined. More recently, medical knowledge like acupuncture and Ayurveda spread from the Far East to the United States and to Western Europe. Pharmacy, homoeopathy, naturopathy and anthroposophical medicine were recognised by German law as 'special schools of therapeutic thought' (*besondere Therapierichtungen*) in 1976. A poly-referential structure of recognising drugs was established. Homoeopathic pharmaceuticals are not tested in double-blind, randomised studies, but are authorised by a committee of doctors engaged in homoeopathy.²⁹ Homoeopathy is practised not only by non-medically qualified personnel, but also by medical doctors. And these doctors can take courses in homoeopathy which are recognised by the German Medical Association (*Bundesärztekammer*).

Homoeopathy differs from biomedicine. The dynamism of the *simile*, the concept of potentisation, is incompatible with biomedical knowledge. Yet, in Hahnemann's (1755–1843) time his medical concept was not too far away from academic concepts. Georg Ernst Stahl (1650–1734) taught that the soul was the dynamic force in human beings; Paul-Joseph Barthez (1734–1806) assumed a principle of life moved the organs; Christoph Wilhelm Hufeland (1762–1836) conceptualised illness as resulting from various stimuli irritating the human vital force. Homoeopathy became a heterodoxy when academic medicine shifted its references from philosophy to natural sciences, while homoeopathy did not. Some additions were made to Hahnemann's concepts, such as Hering's (1800–80) rule³⁰ or Vitthoukas's cybernetic mechanism of defence.³¹ But the Hahnemann core of homoeopathic concepts did not change. Homoeopathy did not change in a changing world of biomedicine, where iatrotechnical and biocybernetic concepts became prevalent.³² Thus, it was excluded from 'normal' science, from biomedicine. Today, it forms part of a body of medical knowledge and practices which are called 'alternative' or 'complementary'. The term 'alternative' went out of fashion, when social movements such as women's liberation, the ecological and the peace movements became integrated into social organisations, including political parties, and when some of their demands became integrated into everyday life. The term 'complementary' refers to an empirical question, whether these forms of medicine are used in a complementary manner to biomedicine. Thus, the non-biomedical forms of medical knowledge are better referred to as 'heterodox'. This term is often used by English social anthropologists. In sociology, it may be ennobled by being traced back to Bourdieu. This knowledge has doctrines of its own, which are opposed by biomedicine. The homoeopathic doctrine is somewhat 'old-fashioned'. Are the patients also 'old-fashioned'?

Sociology of the Heterodox and Homoeopathic Patient

AN OLD-FASHIONED FORM OF MEDICINE is folk medicine. It can be defined by: (1) the notion of transmission and the notion of tradition associated with it; (2) the intervention of oral culture; and (3) the marginalised situation of folk culture.³³ While this folk medicine flourishes in the countryside and in medically under-served areas, this is not true for other forms of heterodox medicine for 'where conventional medicine increases its coverage, complementary medicine follows suit'.³⁴ Empirical studies on patients of heterodox therapists were published in Britain, the USA, the Netherlands and Australia which have been synthesised by

Fuller.³⁵ Heterodox patients were 'predominantly young to middle-aged'. They appeared to come 'from all social classes.' However, there were more patients from professional, managerial, technical, business and academic backgrounds than from other backgrounds. 'They are also likely to be more highly educated than [biomedical] doctors' patients ... Nearly two thirds of the patients are women, much the same distribution as doctors' patients.'³⁶

Sharma³⁷ found three types of users of heterodox medicine: the experimental or eclectic user, the stable and regular user of one form of alternative medicine, and the 'restricted' user of one form of alternative medicine for a single illness. Generally, 'smart users' of heterodox medicine are said to increase in number.³⁸ They come close to Sharma's type of eclectic user. There are patients following an 'alternative medical ideology', on the one hand, found especially among AIDS patients and, on the other hand, those following spiritual healers. This is also true among acupuncture patients.³⁹ Elder *et al.*⁴⁰ reported on a group of users who denied the use of pills or surgery, in general, while others used heterodox and biomedicine in pragmatic and complementary ways.⁴¹ Two studies found acupuncture patients adhering more closely to anti-biomedical ideologies,⁴² while homoeopathic patients did not differ from others in this point. This is a surprising result, which Furnham *et al.*⁴³ explained by the fact that the homoeopathic patients who had been questioned were out-patients of the Royal Homoeopathic Hospital. This hospital is part of the National Health Service, and maybe the patients did not specially select it as a provider of medical care.

Studies which focus on homoeopathic patients will now be outlined. Furnham and Smith found that 'two groups of patients, one visiting a G[eneral] P[ractitioner] and the other a homoeopath, were not significantly different in terms of sex, age, education, marital status, religion and income.' But 'the homoeopathic group were much more critical and sceptical about the efficacy of traditional medicine ... (They did so) from disenchantment with, and bad experiences of, traditional medical practitioners, rather than believing that traditional is itself ineffective.'⁴⁴ This particular disenchantment of homoeopathic patients with biomedicine was corroborated by Vincent and Furnham.⁴⁵ Biomedicine is called 'traditional' whereby prompting the question whether the authors imply that homoeopathy is more modern? Furnham and Smith enquired into the characteristics of homoeopathic patients. May and Sirur put the question the other way round. They explored the ways in which medically qualified practitioners employed homoeopathic treatments in their everyday work

within the British National Health Service. They found some significant aspects for the sociology of homoeopathic patients:

The profession now recognises much minor illness and chronic health problems (low back pain and other musculoskeletal problems; undifferentiated syndromes and fatigue), in terms of psychological rather than somatic categories. The homoeopathic consultation, with its detailed account of the 'personality' of the patient, offered a means of recovering not only the patient's authentic self to medicine, but also detailing more precisely the connections between somatic and psychological problems.⁴⁶

These results concerning the illnesses for which homoeopathy is seen to be efficient correspond to other data outlining the use of heterodox medicine.⁴⁷ The second point made by May and Sirur is the special character of the homoeopathic consultation. This is corroborated by an empirical study by Fairclough, who distinguished between a biomedical type of medical interview, which is characterised by cycles of question by the doctor, answer by the patient, judgement by the doctor, and a heterodox type, where the patient speaks for a long time.⁴⁸ This comes close to Shorter's 'traditional' form of medical consultation.

Scott published a study on 'homoeopathy as a feminist form of medicine'. She interviewed British non-medically qualified female homoeopaths and saw the feminist character of homoeopathy. 'Homoeopaths, and particularly feminist homoeopaths, have begun creating a "holistic" system of medicine which addresses the problem of [biomedical] ontological dualism [of body and soul].'⁴⁹ Commenting upon this holism Scott found 'a complex medicalisation/demmedicalisation movement at work within the alternative ... therapies. While their tendency to shift power and responsibility from the practitioner to the patient is demmedicalising, their tendency to bring all of social life within the medical domain can be profoundly medicalising.'⁵⁰ Armstrong had argued about this dualism between medicalisation and demmedicalisation. From a Foucauldian perspective, he interpreted the integration of patients' accounts into medical work as a new medical perspective. While the perspective analysed by Foucault had made the sick man disappear from medical cosmology about 1800,⁵¹ the sick person re-entered biomedicine after the Second World War. This new perspective completed medicalisation.⁵²

Conclusion

THE HOMOEOPATHIC DOCTOR–PATIENT RELATIONSHIP is both traditional and postmodern. Patients played an active role in the client-dominated medicine about 1800 as their account formed an important part of medical consultation, not only in homoeopathy. With the development of hospital and laboratory medicine the importance of these accounts was replaced by medical data produced by artefacts. The patients' role became passive and merely complementary to the doctors' role. Today, this medicalised role is criticised widely as even biomedical authors demand patients' activities and responsibility. These are elements of the postmodern patients' role, which corresponds in some way to the traditional and the modern role of the homoeopathic patient.

Notes

- 1 Friedrich Oetker, *Lebenserinnerungen* (2 vols., Stuttgart, 1878), I, 31.
- 2 C.f. Claudia Huerkamp, *Der Aufstieg der Ärzte im 19. Jahrhundert* (Göttingen, 1985) and Gerd Göckenjan, *Kurieren und Staat machen. Gesundheit und Medizin in der bürgerlichen Welt* (Frankfurt, 1985) in Germany; Roy Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in Preindustrial Society* (Cambridge, 1985) and Roy Porter and Dorothy Porter, *In Sickness and in Health. The British Experience 1650–1850* (London, 1988) in UK; Jean-Pierre Goubert, 'The Medicalization of French Society at the End of the Ancien Régime' in Lloyd G. Stevenson (ed.), *The Celebration of Medical History* (Baltimore and London, 1982), 157–72 and Matthew Ramsay, *Professional and Popular Medicine in France, 1770–1830* (Cambridge, 1988) in France and John Harley Warner, *The Therapeutic Perspective. Medical Practice, Knowledge, and Identity in America, 1820–1885* (Cambridge, MA, 1986) in the US.
- 3 C.f. Andrew Abbott, *The System of Professions* (Chicago, 1988).
- 4 C.f. Edward Shorter, 'The history of the doctor–patient relationship' in W.F. Bynum and Roy Porter (eds.), *Companion Encyclopedia of the History of Medicine* (2 vols., London and New York, 1993) 2, 783–800, 784.
- 5 C.f. Alain Touraine, *Post-industrial Society* (New York, 1971; French edition, 1969), Daniel Bell, *The Coming of Post-industrial Society* (New York, 1973), Nico Stehr, *Knowledge Societies* (London, 1994) and Gerhard Schulze, *Die Erlebnis-Gesellschaft* (Frankfurt and New York, 1992).
- 6 C.f. N.D. Jewson, 'Medical knowledge and the patronage system in eighteenth-century England', *Sociology* 8 (1974), 369–85.
- 7 Jens Lachmund and Gunnar Stollberg, *Patientenwelten. Krankheit und Medizin vom späten 18. bis zum frühen 20. Jahrhundert im Spiegel von Autobiographien* (Opladen, 1995), chapter 3.
- 8 Shorter, 'Doctor–patient relationship', 784.
- 9 Talcott Parsons, *The Social System* (New York, 1951; Glencoe, IL, 1958).
- 10 C.f. Michael Bury, *Health and Illness in a Changing Society* (London and New York, 1997). Bury called Parsons' model of doctor–patient relationship a 'consensus model', and confronted it with Freidson's 'conflict model' and with Goffman's and Strauss's 'negotiation model'.
- 11 Huerkamp, *Der Aufstieg der Ärzte*, 131 ff.
- 12 C.f. Eliot Freidson, *Profession of Medicine* (New York, 1970), chapter 14.
- 13 Thomas Bliesener, *Die Visite – ein verhinderter Dialog. Initiativen von Patienten und Abweisungen durch das Personal* (Tübingen 1982).
- 14 Uta Quasthoff-Hartmann, 'Frageaktivitäten von Patienten in Visitengesprächen' in Karl Köhle and Hans-Heinrich Raspe (eds.), *Das Gespräch während der ärztlichen Visite* (Hamburg, 1982), 7–101.

- 15 Jürgen Glück, Eduard Matt and Elmar Weingarten, 'Sprachliche Realisierung von hierarchischen Kontexten' in Hans-Georg Soeffner (ed.), *Beiträge zu einer Soziologie der Interaktion* (Frankfurt, New York, 1984).
- 16 Eva-Maria Rellecke, 'Selbstverantwortung und Mitbestimmung des Patienten bei seiner Behandlung' in Petra Löning and Sven F. Sager (eds.), *Kommunikationsanalysen ärztlicher Gespräche* (Hamburg, 1986), 39–83.
- 17 Elliot G. Mishler, *The Discourse of Medicine: Dialectics of Medical Interviews* (Norwood, 1984).
- 18 Paul Atkinson, *Medical Talk and Medical Work. The Liturgy of the Clinic* (London, 1995).
- 19 C.f. W.J. Scott, 'PTSD, in DSM-III: a Case in the Politics of Diagnosis and Disease', *Social Problems* 37 (1990), 294–310 and Allan Young, 'Reconstructing Rational Minds: Psychiatry and Morality in the Treatment of Posttraumatic Stress Disorder' in Jens Lachmund and Gunnar Stollberg (eds.), *The Social Construction of Illness* (Stuttgart, 1992), 115–24.
- 20 C.f. A. Johnson and K. Hufbauer, 'Sudden Infant Death Syndrome as a Medical Research Problem since 1945', *Social Problems* 30 (1982), 65–81.
- 21 C.f. Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization* (St Louis, 1980), chapter 7 and, for further examples, Hilary Arksey, 'Expert and Lay Participation in the Construction of Medical Knowledge', *Sociology of Health and Illness* 16 (1994), 448–68.
- 22 C.f. Freidson, *Profession of Medicine*, chapter 13.
- 23 David Tuckett *et al.*, *Meetings between Experts: An Approach to Sharing Ideas in Medical Consultations* (London and New York, 1985), 148.
- 24 Dick Willems, 'Susan's Breathlessness B The Construction of Professionals and Laypersons' in Lachmund and Stollberg (eds.), *Social Construction of Illness*, 105–14, 113.
- 25 Elisabeth Gülich, "'Experten und Laien": Der Umgang mit Kompetenzunterschieden am Beispiel medizinischer Kommunikation' in Konferenz der deutschen Akademien der Wissenschaften und der Sächsischen Akademie der Wissenschaften (ed.), *Werkzeug Sprache. Sprachpolitik, Sprachfähigkeit, Sprache und Macht* (Hildesheim, 2000), 16.
- 26 Anthony Giddens, *Beyond Left and Right* (Cambridge, 1994), 95 ff.
- 27 Alfred Schütz, 'The Well-Informed Citizen' in Alfred Schutz (ed.), *Collected Papers II* (The Hague, 1964), 120–34, 122 ff.
- 28 C.f. Arthur Kleinman, *Patients and Healers in the Context of Culture. An Exploration of the Borderline between Anthropology, Medicine, and Psychiatry* (Berkeley, 1980).
- 29 C.f. Herrmann Plagemann, *Der Wirksamkeitsnachweis nach dem Arzneimittelgesetz von 1976. Funktionen und Folgen eines unbestimmten Rechtsbegriffs* (Baden-Baden, 1979) and Karl-Heinz von Kevelaer, *Das Arzneimittelgesetz von 1976. Entstehungsbedingungen und Entscheidungsprozeß* (Dipl.-Soz. thesis, Bielefeld, 1980).

- 30 During the process of healing the symptoms move from inside to outside, from top down, and vanish in reverse order. For Hering see Reinhart Schüppel, 'Constantin Hering (1800–1880): Ein Akademiker gründet Institutionen' in Martin Dinges (ed.), *Homöopathie. Patienten, Heilkunde, Institutionen. Von den Anfängen bis heute* (Heidelberg, 1996), 296–317.
- 31 Stressors produce symptoms in bodies, even when homeostasis is maintained. Thus, symptoms should not be suppressed. C.f. George Vithoulkas, *The Science of Homoeopathy* (Wellingborough, 1986).
- 32 C.f. Karl Eduard Rothschiuh, *Konzepte der Medizin in Vergangenheit und Gegenwart* (Stuttgart, 1978) and Cornelius Borck, 'Anatomien medizinischer Erkenntnis' in Cornelius Borck (ed.), *Anatomien medizinischen Wissens. Medizin, Macht, Moleküle* (Frankfurt, 1996), 9–54.
- 33 Françoise Loux, 'Folk Medicine' in Bynum and Porter (eds.), *Companion Encyclopedia*, 661–75, 661.
- 34 Stephen Fuller, *The Handbook of Complementary Medicine* (3rd ed., Oxford, 1996), 34.
- 35 C.f. Fuller, *Handbook*, 31 ff.
- 36 C.f. Fuller, *Handbook*, 35 ff.
- 37 Ursula M. Sharma, *Complementary Medicine Today. Practitioners and Patients* (London and New York, 1992), 42 ff. and Ursula M. Sharma, 'Using Alternative Therapies: Marginal Medicine and Central Concerns' in Basiro Davey, Alastair Gray and Clive Seale (eds.), *Health and Disease. A Reader* (2nd ed., Buckingham, PA, 1995), 137.
- 38 Merrijoy Kelner and Beverly Wellman, 'Health Care and Consumer Choice: Medical and Alternative Therapies', *Social Science and Medicine* 45, 2 (1997), 203–12, 211.
- 39 Kelner and Wellman, 'Health Care and Consumer Choice' and Adrian Furnham, Charles Vincent and Rachel Wood, 'The Health Beliefs and Behaviors of Three Groups of Complementary Medicine and a General Group of Patients', *The Journal of Alternative and Complementary Medicine* 1, 4 (1995), 347–59.
- 40 Nancy C. Elder and Amy Gillcris, 'Use of Alternative Health Care by Family Practice Patients', *Archives of Family Medicine* 6 (1997), 181–84.
- 41 Jahn A. Astin, 'Why Patients Use Alternative Medicine. Results of a National Study', *Journal of American Medical Association* 19, 297 (1998), 1548–53.
- 42 Furnham *et al.*, 'Health Beliefs and Behaviors', and Elder and Gillcris, 'Use of Alternative Health Care'.
- 43 Furnham *et al.*, 'Health Beliefs and Behaviors'.
- 44 Adrian Furnham and Chris Smith, 'Choosing alternative medicine: a comparison of the beliefs of patients visiting a general practitioner and a homoeopath', *Social Sciences and Medicine* 26 (1988), 7, 685–89, 685.

- 45 Charles Vincent and Adrian Furnham, 'Why Do Patients Turn to Complementary Medicine?', *British Journal of Clinical Psychology* 35 (1996), 37–48.
- 46 Carl May and Deepak Sirur, 'Art, Science and Placebo: Incorporating Homoeopathy in General Practice', *Sociology of Health and Illness* 20 (1998), 168–90, 173.
- 47 E.g. c.f. Fuller, *Handbook*, Helle Johannessen, *An Overview of Alternative Medicine in Europe* (MS Ruds Vedby, 1997) and Sharma, *Complementary Medicine*. More extensively, Walter Andritzky, *Alternative Gesundheitskultur* (Berlin, 1997), 32 ff. For an overview on studies about the effectiveness of homoeopathy see Joachim Hornung, 'Quo vadis Homöopathieforschung? Über klinische Studien und Arzneimittelprüfung am Gesunden in der Homöopathie' *Forschende Komplementärmedizin*, 3 (1996), 91–101. His result is that this effectiveness was neither proved nor disproved, though there is a multitude of studies. In their popular book based on scientific evidence, Bettschart *et al.* represent homoeopathy as being potentially helpful in many chronic and psychosomatic illnesses. C.f. Roland Bettschart *et al.*, *Bittere Naturmedizin. Wirkung und Bewertung der alternativen Behandlungsmethoden, Diagnoseverfahren und Arzneimittel* (Köln, 1995), 808.
- 48 Norman Fairclough, *Discourse and Social Change* (Cambridge, 1992), 142 and 146.
- 49 Anne Scott, 'Homoeopathy as a Feminist Form of Medicine' *Sociology of Health and Illness* 20 (1998), 191–214, 210.
- 50 Scott, 'Homoeopathy', 209.
- 51 C.f. N.D. Jewson, 'The disappearance of the sick man from medical cosmology, 1770–1880', *Sociology* 10 (1976), 225–44.
- 52 David Armstrong, *Political Anatomy of the Body* (Cambridge, 1983). For his criticism of holism see David Armstrong, 'The Problem of the Whole-Person in Holistic Medicine', *Holistic Medicine* 1 (1986), 27–36.

